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The International Journal of Psychoanalysis – 89(3), pp. 523-540 (2008)

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Is there still a place for the concept of ‘therapeutic regression’ in psychoanalysis?

Laurence S. Spurling

The author uses his own failure to find a place for the idea of therapeutic regression in his clinical thinking or practice as the basis for an investigation into its meaning and usefulness. He makes a distinction between three ways the term ‘regression’ is used in psychoanalytic discourse: as a way of evoking a primitive level of experience; as a reminder in some clinical situations of the value of non-intervention on the part of the analyst; and as a description of a phase of an analytic treatment with some patients where the analyst needs to put aside normal analytic technique in order to foster a regression in the patient. It is this third meaning, which the author terms “therapeutic regression” that this paper examines, principally by means of an extended discussion of two clinical examples of a patient making a so-called therapeutic regression, one given by Winnicott and the other by Masud Khan. The author argues that in these examples the introduction of the concept of therapeutic regression obscures rather than clarifies the clinical process. He concludes that, as a substantial clinical concept, the idea of therapeutic regression has outlived its usefulness. However he also notes that many psychoanalytic writers continue to find a use for the more generic concept of regression, and that the very engagement with the more particular idea of therapeutic regression has value in provoking questions as to what is truly therapeutic in psychoanalytic treatment.

Introduction

One of the more enduring ideas in psychoanalysis is that of some patients needing a period of regression during their treatment, and that such a regression can only be allowed by the analyst putting aside their normal analytic technique. To meet this therapeutic regression in the patient, so the argument runs, analysts must learn to give up on their normal expectation that the patient put their thoughts and feelings into words. Instead the analyst should convey to the patient that what is required is “an ordinary abandonment ... of reporting and thinking oneself out” (Bollas, 1987, p. 259). What counts here is not facility with interpretation, even interpretations specifically designed to appeal to the patient who is hard to reach. A different kind of attention to the regressed patient is required, one based on the qualities of “reception, musing and evocation” (Bollas, 1987, p. 273). Such an attitude invokes what Michael Balint called an object-relation based on the structure of a primary object, “an environment that accepts and consents to sustain and carry the patient like the earth or water sustains and carries a man who entrusts his weight to it” (Balint, 1968, p. 45). Winnicott preferred the model for the analyst to be that of the mother who ‘holds’ an infant totally dependent on her care and attention in order to survive and to flourish.

As someone who has drawn inspiration from Winnicott's work (Spurling, 2003), I have long been fascinated by these ideas on therapeutic regression. I have found them a welcome reminder of the inescapably aesthetic and intuitive aspects of the analytic attitude. However, I have also struggled to turn the concept of therapeutic regression into a meaningful idea, and been unable to find a place for it in my clinical thinking. The problem was that my patients just did not seem to regress in the ways described in the literature. To be sure, as they became engaged in their treatment they became dependent and vulnerable, sometimes intensely so, and with some patients there were times in the work when all that seemed to matter was whether or not I was able to adapt sufficiently to their needs. But such clinical situations, familiar to all practitioners, did not form themselves in my mind into a discernible phase of therapeutic regression. Nor did they seem to demand from me a different kind of analytic sensitivity over and above my attempts to embody my normal way of working.

At first I put this down to lack of experience and confidence on my part. After all, Winnicott advised those in the first decade of their analytic career not to give up the "principles of ordinary practice" in taking on patients needing a regression (1954a, p. 293). But becoming more clinically experienced and confident, especially in working with more disturbed patients in more intensive and extended treatments (e.g. Spurling, 2005), did not bring the expected insight into my patients' hitherto unrecognized need to make a therapeutic regression. On the contrary, this only seemed to confirm that the idea of my patients making a therapeutic regression had become redundant to me.

In trying to make sense of this apparent failure on my part to find value in the concept, I went back to the literature. But now I found that the harder I looked to discover what therapeutic regression really meant, and how to recognize it, the less I was able to see it. Either the phenomena being described – the patient getting in touch with bodily or pre-symbolic experiences or feelings, the patient finding a need for silence as a prelude to thinking or feeling, etc. – did not seem to me to be very different from the normal things that patients do in treatment, and did not warrant the use of a special term. Or the writer seemed to be describing a connection with the patient that went beyond the intensely felt transference experiences which arise in therapy or analysis, claiming to bring about a different order of experience for the patient only available to the patient fortunate enough to be working with an analyst who believed in the value of therapeutic regression.

Looking at contemporary accounts in the analytic literature, I think that my failure to engage with the idea of therapeutic regression reflects a general unease in the psychoanalytic community with the whole idea of regression. A good illustration of this is the change in tone between a 1958 and a 1999 report of a panel discussion on regression in the *Journal of the American Psychoanalytic Association*. The 1958 panel was called on to discuss 'technical aspects of regression during psychoanalysis', and the report describes the panel as having discussed "two problems of psychoanalytic treatment: how to handle too little regression and how to handle too much regression" (Calder, 1958, p. 554). In the 1999 panel the topic for the panel had become 'regression: essential clinical condition or iatrogenic phenomenon?', with the panel called on to consider whether analysts "view regression as indispensable, incidental or inimical to analytic work?" (Goldberg, 1999, p. 1168). In the 1958 panel it seemed to have been assumed that regression was a beneficial

part of analytic therapy, the only question being how to gauge the optimum amount of regression in the patient in order for the treatment to do well. But by 1999 the panellists' attitude towards regression was no longer so positive, expressing doubt about its effectiveness and concern about whether it might do more harm than good.

How is the concept of regression used in psychoanalytic writing?

A major difficulty in trying to write about the concept of regression in psychoanalysis is that it is used in very different ways. Its most basic meaning is as a purely descriptive term, applied to a psychical process having a determinate course or evolution (Laplanche and Pontalis, 1988, p. 386). This use of the concept of regression goes back to Freud who used the concept in two main senses: firstly in a spatial or topographical sense, to describe the way in the psychical apparatus that excitations, represented by wishes or impulses can retrace a pathway which has already been established. In a progressive direction this pathway leads from the perceptual apparatus towards expression as thoughts. In a regression, the movement would be in the reverse direction, with thoughts being transformed back into images, and then, in a further movement, backwards into dreams or hallucinations (Jackson, 1969, p. 773).

Freud continued to use regression in a topographical sense throughout his writings. But he increasingly used regression in another way, a temporal sense, meaning a return, usually in the form of a fixation, to an earlier stage of development. Freud also made reference to a third meaning of regression, which he called formal regression, with the sense of a backwards movements not to a stage but to a less developed function or structure, as in a movement from secondary to primary process thinking.

Freud saw the manifestation of a regression in analysis as a mark of resistance, a defence against remembering and working through: "I do not know of a passage in Freud's writings which dealt at any length with the problems of therapeutic, not of defensive or pathogenic, regression" (Balint, 1968, p. 123). This is the way regression continues to be widely used in the psychoanalytic literature, to denote a retreat from development in the face of anxiety or conflict. Nevertheless Freud also recognized that if there is no regression on the part of the patient, and therefore no access to primary process thinking and primitive experiences, there can be no analysis. So as well as being wary of regression in the patient, the analyst needs at the same time to be able to allow its development, to be able, as Sandler and Sandler put it in their review of the concept, to tolerate in the patient "the perverse, the silly, the stupid, the infantile and the ridiculous" (Sandler and Sandler, 1984, p. 433).

This dual ambiguity – over what manner of regression is meant, and over whether regression in the patient is a sign of resistance or of development – has led to a situation where "we do not have a very precise psychoanalytic definition of the concept as it is currently employed" (Sandler and Sandler, 1984, p. 431). Furthermore it is used in different ways in analytic discourse, to do different things, and it is helpful to distinguish what these are.

1. 'Regression' as an evocation of the primitive

Laplanche and Pontalis (1988) begin their definition of regression by remarking that it is a term often 'evoked' in psychoanalytic writing. I think to speak of an evocation here is precisely the right word, as much of the time this is how the term functions, to convey the arrival of something primitive in the treatment, whether it be a level of development, of experience or part of the mind in the patient, or a primitive form of relationship between patient and therapist.

2. 'Regression' as a call for non-intervention

To describe a psychical process as regressive, or a patient as regressed, does not in itself have any particular consequences for one's clinical thinking, beyond noting the emergence of something more primitive. However, there is a tradition of thought within psychoanalysis, starting with Ferenczi's "principle of relaxation" (Balint, 1968, p. 151) and then re-surfacing with the work of Balint and Winnicott, and in the work of Kris and others in the USA which argues that there is a bias in psychoanalytic thinking towards seeing regression in its pathological rather than its therapeutic sense, and that this bias is a result of an over-valuation of interpretation or more active interventions with the patient. This can be illustrated by some comments made by Harold Stewart (1992), in the course of illustrating 'therapeutic regression' as an agent of psychic change, about a case example given by Hanna Segal.

Segal writes of a patient who during the course of his analysis became increasingly aware of his obsession with women's breasts. Following a dream in which a woman is giving her breast to a baby, the patient complains to his analyst that now all he can think about is her breasts, and tells her that, as a child, he was always sucking something. Segal points out to him that, while he has been talking, he has been getting "more and more dreamy and remote", and goes on to remind him that in his dream the woman who gave the baby her breasts went on to leave him. The patient interrupts her angrily, saying: "Don't make me think, I don't want to think. I want to suck. I hate thoughts. When I have thoughts, it means I have nothing to suck" (Segal, 1986, pp. 222–3). Segal uses this example to illustrate what she calls the "hatred of thought processes" in the patient, that he experienced her interpretation as shattering his illusion of the breast as an ideal object.

Stewart comments that Segal's intervention was perfectly correct, but that:

Something different might have been done at this point in the session when the patient began to get dreamy and remote. Instead of making an interpretation, no matter how correct it was, the analyst might have remained still and silent to allow the patient to reach and explore for himself the experience of being in this state in the presence of an analyst who is not intervening with an interpretation, since this is experienced as a request for thinking about something instead of simply experiencing.

(Stewart, 1992, p. 133)

Stewart's comments can be taken as offering a different reading of the clinical material, one in which the patient's dreamy and remote state is taken as a sign that he is in touch with a primitive state of mind, wanting to suck. Instead of a way of avoiding something, this is taken as a prelude towards some form of self-experience, what Winnicott called 'a regression to dependence', or what Balint called

an experience of life having become “simpler and truer” (Balint, 1968, p. 135). Here the patient’s ‘non-communication’ would be seen as a ‘positive contribution’ (Winnicott, 1963a), needing an attitude on the part of the analyst which would allow him to complete an experience. An analogy here would be with the infants and children in Winnicott’s spatula game, who needed a ‘period of hesitation’ before they were ready to reach for and play with the shiny spatula on the table in front of them in order to overcome their anxiety, and so as a necessary step before they could go on to experience pleasure and self-mastery (Winnicott, 1941).

To describe the patient’s state of mind here as regressed (Stewart does not actually refer to the patient as ‘regressed’, but it is clear that this is what he means to indicate) is not only to point to the emergence of something primitive in the patient, but also to say that this emergence is dependent upon the analyst recognizing this clinical event as a regression, and being prepared to find a form of clinical intervention which allows this regressive development rather than spoils or short-circuits it. The most appropriate kind of response, as the example illustrates, is one of non-intervention by the analyst, that is, an active refraining from intervention in order to give the patient’s self-experience sufficient time and space to unfold. For instance, Bollas, in describing his work with a patient who from time to time would fall asleep or remain silent for long periods, refers to his non-intervening attitude as a way of “defending the patient’s right to an experience”, a right in danger of being violated by any form of analytic interventionist technique at this point (Bollas, 1987, p. 268).

Where the analyst decides that some form of intervention might be appropriate, it should embody an attitude which Balint described as being ‘unobtrusive’, which means not becoming too separate, or too much of a sharply-contoured object. Stewart argues, for instance, that, when working with a patient who is regressed, transference interpretations are to be avoided as these would establish the analyst as both separate and omnipotent (Stewart, 1992, p. 117) – precisely his critique of the position adopted by Segal in this example.

If, following this way of thinking, one were to imagine an analyst deciding that some form of interpretation, other than a transference interpretation, should be made to Segal’s patient, it would be likely to be one which endorsed the way the patient was trying to make use of the analyst and the setting of the analysis, perhaps represented by the analyst’s breasts, to gain access to his self-experience. In other words, the emphasis would be on the interpretation conveying a sense of the holding function of the therapist rather than on giving understanding. An example of this would be that of Winnicott (1954b) in his paper *Withdrawal and regression*, where he made a series of interpretations to a deeply schizoid patient which helped the patient recognize the development in himself of a capacity for spontaneity through a dawning trust in the analytic setting.

3. ‘Regression’ as a therapeutic phase of treatment to be fostered by putting aside ordinary analytic technique

The idea of regression as a call for non-intervention, as in Stewart’s critique of Segal, turns on the reading of a particular clinical event – is it an example of pathological dissociation or of developing self-experience? – and the consequent choice of clinical intervention – interpretation or silence? What is not in dispute is the

overall aim of the analysis at this point, which is to reach or contain the patient using the techniques of ordinary analysis.

However, the term regression can also be used in a more radical sense, to designate not a disagreement over whether a particular intervention is appropriate or not, but to argue that normal analytic technique itself may be inappropriate when working with some regressed patients. The critique of Segal here would not be that she chose the wrong intervention, but that the very assumptions of her clinical thinking prevented her from recognizing that her patient was in a regressed state, and so (unwittingly) represented a violation of what Winnicott called the patient's process, "that which in each patient has its own pace and which follows its own course" (1954a, p. 278). In this view, sometimes, particularly when the patient becomes severely regressed, protecting the patient's process from impingement becomes the paramount aim of analysis. The problem with normal analytic technique, however, is that it mistakes the patient's trying to convey to the analyst what he or she needs for a demand that the analyst gratify their desire:

It is proper to speak of the patient's wishes, the wish (for instance) to be quiet. With the regressed patient the word wish is incorrect; instead we use the word need. If a regressed patient needs quiet, then without it nothing can be done at all.

(Winnicott, 1954a, p. 288)

Following the patient's process to its more primitive levels in a therapeutic regression may mean that the analyst needs to do something "in addition to – but not instead of – what happens in a 'classical' analytic treatment" (Balint, 1968, p. 128, *italics added*). Or it may involve doing something instead of what the analyst would normally do, as Winnicott advised in the treatment of patients who were making a 'sustained regression' – "sometimes over long periods with these patients ordinary analytic work has to be in abeyance" (Winnicott, 1954a, p. 279). Bollas develops this idea a little further by distinguishing between two types of transference experience. In ordinary analytic work the analyst strives to foster a normal transference relationship, which "involves the analysand and analyst in the patient's evolved projective and introjective activities lived out in the analytic relationship" (Bollas, 1987, p. 247). But in periods when the patient is regressed, Bollas sees it as his task to foster a different class of transference experience, one that involves him as a "transformational object", in which he is engaged by the patient as "an auxiliary to the process of knowing the self" (*ibid.*). Analysts whose technique does not allow them to be used by their patients in this way will never enable their patients to reach these depths of self-experience (Bollas, 1987, p. 261; Tuttleman, 1979).

It is regression in this sense that I am referring to as therapeutic regression. It comprises two ideas. The first is that some patients, in order to reach levels of self-experience, need a period of sustained regression in their treatment. The second is that, with some patients, it may not be sufficient to allow their regression; it may need to be more actively fostered by the analyst. In order to do so, the analyst must be prepared to supplement or replace ordinary analytic technique with a different way of working.

The form of regression indicated in this sense of therapeutic regression has been described by different authors in various ways. It is usually characterized as a formal regression, regression to more primitive forms of behaving and experiencing (Balint, 1968, p.130). Regression also seems to have a topographical dimension,

with the idea of getting in touch with a distinct area of the mind or personality: the area of the ‘basic fault’ (Balint), or the ‘true self’ (Winnicott), or creative part of the mind (Kris). When it comes to regression in its temporal sense, the picture is less clear. This kind of regression, for example, does not figure in Abram’s definition of what Winnicott meant by regression (Abram, 1996), which she defines as a formal regression to a state of dependence. But it is hard to think of regression without some idea of a return to an earlier state. Indeed Winnicott’s writings are shot through with his idea that his regressed patients were actually re-living aspects of previous traumatic experiences in the sessions with him, such as a difficult birth experience (Winnicott, 1949, p. 249): “‘whereas in the transference neurosis the past comes into the consulting-room, in this work it is more true to say that the present goes back into the past, and is the past (Winnicott, 1955, pp. 297–8).

These ambiguities as to the precise form of regression are not taken as decisive, however, as the emphasis in the writing on therapeutic regression is that it is a regression within the analytic relationship itself. It is a return to the infantile state of dependence on the setting (Winnicott), or of a harmonious mix-up between analyst and patient (Balint). The important point about this relationship is that it is seen as exclusively two-person, on the model of nurturing mother and dependent infant, with the analyst / mother’s job to protect the infant / patient from unnecessary impingements: “‘any third party interfering with this relationship is experienced as a heavy burden or as an intolerable strain’” (Balint, 1968, p. 17).

The point of the patient making a therapeutic regression during treatment is that it then becomes the basis for what Balint called ‘a new beginning’. For Winnicott a regression could serve as a mobilization of hope:

an unconscious assumption (which can become a conscious hope) that what when wrong in the past – where the environment failed to hold or protect the person – may be re-experienced, with the individual in a regressed state, but now in an environment which is making adequate provision.

(Winnicott, 1954a, p. 282)

What is the ‘something’ that needs to be added to or to replace normal analytic technique in a therapeutic regression?

A major problem in trying to understand what is actually meant by the idea of a therapeutic regression, and particularly its claim that normal analytic technique needs to be superseded in some way, is that there exist few accounts in the literature which are both clearly about a regression used in this sense (and not simply an evocation of the primitive or a call for non-intervention), and also detailed enough to convey what is actually involved (Margaret Little [1985] makes this point).

The most widely known ways in which advocates of therapeutic regression went beyond normal technique are also the most controversial, as they consisted of making changes to the normal parameters of analytic treatment. Balint allowed his regressed patients to telephone him out of session times, and allowed finger- and hand-holding, arguing that often some form of physical contact was “‘always vitally important for the progress of the treatment’” (1968, p. 145). Winnicott sometimes gave longer sessions, and would hold the hand or head of regressed patients, as Margaret Little describes: “‘literally, through many long hours, he held my two

hands clasped between his, almost like an umbilical cord” (Little, 1985, p. 21). The danger of this approach ending up with the analyst committing serious boundary violations is now widely recognized (e.g. Gabbard, 2003), and the modern view of those who believe in the value of therapeutic regression would be that Balint and Winnicott did not pay sufficient attention to the capacity of the patient to manage such modifications to the treatment setting (Stewart, 1992, p. 119; White, 2006a).

But beyond an emphasis on flexibility in the maintenance of therapeutic boundaries with regressed patients, it is not easy to gain a sense of what the analyst actually does with a patient supposedly going through a period of therapeutic regression. The clearest picture I have got of what Winnicott might have meant comes from a paper based on his notes from a seminar he gave to trainees at the Institute of Psychoanalysis, where he seemed to have felt he could speak with more candour about his work.

In this paper Winnicott describes a session with a patient he describes as deeply regressed, whose dependence on the therapy has become so great that she is “past the point of no return” (1964, p. 98). With a patient in such a deeply regressed state, not only are the utter reliability and predictability of the setting of overriding importance, but also the analyst’s ability to adapt the environmental provision to the particular needs of the patient:

In regard to this patient there are certain things that have to be the same always. The curtains are drawn; the door is on the latch so that the patient can come straight in; all the arrangements in the room must be constant and also there are some objects which are variable but which belong to the transference relationship. At the time I am describing, the constant object is placed in a certain position on the desk and there are certain papers which have accumulated which I put beside me waiting for the moment when the patient will want them back.

(Winnicott, 1964, p. 98)

However at the particular session Winnicott is describing, “in spite of careful inspection of my arrangements of the room”, something goes wrong, the papers have been left on top of instead of beside the other object. The patient enters the room and discovers the alterations, and, when Winnicott himself enters the room, “I find that this is a complete disaster ... I know that I shall be lucky if we recover from this disaster in a matter of weeks” (p. 99).

Indeed at first the patient reacts in an ‘extreme fashion’, but on this occasion she is able to recover and is eventually able to ask herself what is it she has done that has caused Winnicott to act in this way? Winnicott tells her that, as far as he can see, this ‘disastrous mistake’ on his part had unconscious motivation. He points out to the patient that she would have much preferred to see what he had done as a reaction to something in herself, as that would bring the whole thing under her control. Instead she must face the possibility that what happened was nothing to do with her. From this the patient took the matter back to certain things about her father, which she had always tried to explain as his reactions to something about her, whereas she now realized that they were characteristics of her father, nothing to do with her. At the end of the session, Winnicott says to the patient that this is what he is like, that he is someone who can act with unconscious motivation, and, if she continues in analysis with him, he will no doubt do similar things again.

What to my mind is well illustrated in this example is Winnicott's interpretive skill when under pressure. He helps the patient recover from her 'extreme reaction' following his mishandling of the set-up, and then speaks to her in a way which helps her see how she deals with trauma by omnipotence, that is, casting herself as the cause of Winnicott's mistake, just as, she is able to realize, she would hold herself responsible for her father's illness. In fact I would think of Winnicott's style here as an idiosyncratic version of Steiner's 'analyst-centred interpretations' (Steiner, 1993), that is, interpretations aimed at facilitating the patient's experience of being understood by focusing on her experience of the analyst, in order to anchor her sufficiently in the session to come to her own (patient-centred) understanding. It could be argued that it was Winnicott's particular way of speaking to his patient which represented what was really radical about his approach, a way of gathering the transference so that the patient could then make use of the session.

But this is not how Winnicott sees it. The point for him of the case was to give an instance of 'regression to dependence', of what might happen if ordinary analytic technique is left to one side, and to see what might then emerge if the patient is allowed a full regression. The implicit argument is that the security and continuity established by the particular environmental provision allowed by Winnicott, the objects in their special place etc., allowed this patient sufficient trust in the environment in order eventually to be able to make use of Winnicott's interventions.

What does come over is how far Winnicott was prepared to go in adapting the setting to his understanding of the needs of the patient. Nevertheless it is not clear whether this in itself represents a departure from normal or accepted practice, as all practitioners learn to apply treatment boundaries flexibly with each patient. What makes it so difficult to make a judgement here is that Winnicott does not seem to consider it important to tell his students why he considered this particular arrangement essential in order to allow the regression by the patient, how it came to be adopted, how it was negotiated, and what he considers some of the consequences might be of making these changes. Instead he makes a direct appeal to his authority:

In the kind of case I am talking about it is never a question of giving satisfactions in the ordinary manner of succumbing to a seduction. It is always that if one provides certain conditions work can be done and if one does not provide these conditions work cannot be done and one might as well not try.

(Winnicott, 1964, p. 97)

What is insistent here is this conception of what the patient needs, a consideration which overrides all other determinants. The analyst seems to see himself under pressure to prove to the patient that he is sufficiently reliable for her to trust him, as with a patient he describes in another context, who emerged from a session in which Winnicott remained as still and silent as he could by telling him: "Now I know you can do my analysis" (1954a, p. 290).

In my view a serious consequence of employing the idea of therapeutic regression is that it turns the analyst's attention away from the transference considerations which are part of normal analytic technique – the self-examination which is a consequence of thinking in terms of the 'normal counter-transference and its deviations' (Money-Kyrle, 1988) – instead keeping the focus on what stops the analyst from making even further adaptations to meet the so-called needs of the patient.

The astonishing thing is that if one has a patient going through one of these phases one can adapt in a very detailed way to the patient's needs over a period of time ... in time, however, one's own unreliability begins to seep through, and one of the dangers is that, as soon as the patient begins to get better in the sense of being able to allow one to lessen vigilance, one is liable to take a holiday, so to speak, and to rush forward with a show of one's own impulse. One cannot be blamed for being like this but it may lose a case that is going well.

(Winnicott, 1964, p. 100)

The question here is: might some of this strain alluded to by Winnicott not simply be an inevitable part of working with very ill patients (which to some extent it must be), but in addition be a consequence of the very assumptions and technique employed in the first place? Is the idea of "very detailed" adaptation to the patient's needs more the product of a fantasy of the patient's, or a construction of both patient and analyst, so that, in appearing to buy into it, the analyst in fact produces a state of expectation or entitlement in the mind of the patient, making the inevitable let-down all the more bitter and hateful (Balint, 1968, p. 116)? And so might the lapses and holidays in vigilance to which Winnicott refers be considered, at least in part, to have been iatrogenically produced?

A further problem is how to link the two parts of the session together. What Winnicott does illustrate is how, after a so-called regressive experience, it is very important that the patient is able to speak about what happened and make sense of it. But whereas in this second part of the session Winnicott's position as analyst is clear, I find it much harder to know what to make of his role in the first part, where he claims to be providing, or failing to provide, the necessary therapeutic conditions for work to be done. So when he writes of his 'disastrous mistake' with his patient in not setting up the room in the way the patient needed, how are we to hear this? Winnicott sets great store by the inevitability, indeed necessity, of the analyst making mistakes, so that the patient can use this failure of the analyst in order to get in touch with anger concerning the original environmental failure (Winnicott, 1954a, p. 289; 1963b, p. 258).] In this sense, as Abram notes in her commentary on Winnicott's concept of regression, the analyst's failure is an "enactment", that is it "has to occur within the transference" (Abram, 1996, p. 257). But it is not clear to me that Winnicott sees his mistake in this way, as part of his relationship with the patient. He writes in the same paper, "although it was a narrow shave ... it can easily be seen that one simply cannot afford to make these mistakes with patients who are more ill" (1964, p. 100), which seems to indicate very clearly that he simply feels he made a serious mistake in not arranging the room in the correct way, despite his careful checking, and that therefore he has to take some responsibility for the patient's subsequent acting out. It is as though Winnicott is not quite sure how seriously or literally to take himself here. Writing of the work of Winnicott and his followers, Michael Balint refers to their "exalted sincerity", demonstrated in "a curious attitude of the analyst which – as reported in our scientific meetings and in the literature – strikes one as apologetic, continuously confessing to mistakes and blunders, failures and shortcomings" (1968, p. 116). What I miss in his account is any sense of irony, that is, some openness to other perspectives which are opened up by a consideration of the transference, for instance, that some kind of folie deux is being played out here.

I have also looked in the literature for an account of therapeutic regression which gives a sense not of how a single session might be conducted, as in the Winnicott

example, but of how the whole period of therapeutic regression might be seen in the context of the analytic treatment as a whole. The clearest example I have come across is one given by Masud Khan. In a particularly vivid and detailed account (which runs over about 30 pages) he describes the development and outcome of what he calls an “anaclitic regression” (Khan, 1960, p. 137) in the course of a three-year analysis.

The patient came to analysis following a breakdown into a state of agitated depression. On one occasion, for example, she had been found wandering away from her home in a state of panic and confusion. In his account Masud Khan divides the analysis into several phases. He calls the first phase, which lasted about seven months, as running “a very smooth and classical course” (p. 144), in that the patient was able to make use of the analyst’s interpretations. This was followed by a period characterized by mania and elation, in which the patient contemptuously withdrew from her friends in the outside world, while at the same time investing the analysis with all her hopes of unlimited success. She adopted an omnipotent attitude, by reassessing all the experiences so far worked on in the analysis, feeling superior to them and creating a “new and unhistorical reality” of her own.

After the first long break in the analysis the manic bouts were replaced by suicidally despairing sadness and grief, punctuated with intense rage against both her husband and her analyst. Following a cruel rejection by her husband, there followed what Masud Khan describes as “a collapse into sheer hopelessness”, a state that was “no longer apathy or depression; it was just being nothing” (p. 154).

This marked for the patient “a gradual and controlled regression to what the patient described as ‘a state of being nothing’ and the emergence from it” (p. 149). During this period, which lasted about three months, the patient almost gave up completely on trying to look after herself, and had to rely on support from friends and colleagues. At the same time the regression involved a “near-absolute” dependence on Masud Khan as the analyst, which at times he understood to mean helping the patient with some of her actual affairs, such as replying to letters from her husband. Masud Khan characterizes the outstanding feature of the regression as “a total and abysmal sense of loss and letting herself experience this loss in all its aspects” (p. 156), although he notes that in some sessions during this period the patient would feel “quite normal” (p. 157). He conveys how allowing his patient’s experiences to affect him helped him be in touch with her. For example, on one occasion when talking of her thoughts of killing herself the patient “started to cry, quietly, gently, and with the whole of her body. I could feel its reality and pain in myself. There was nothing of her strength left, she felt; and this also I could feel” (p. 154). He describes his main role during this period as:

to be there, alive, alert, embodied and vital, but not to impinge with any personal need to translate her affective experiences into their mental correlates ... If I was not all there in my body-attention she would register it right away.

(Khan, 1960, p. 157)

This phase culminated in an overdose of sleeping pills, which then ushered in a period of recovery. However, following another rejection by her husband, the patient developed ‘a most resolute and paranoid state’, which lasted six months.

She now felt that the whole analysis had been a hoax, and that the analyst, husband and referring psychiatrist were conspiring against her. During this period Masud Khan had to struggle with a quite conscious fear that she would kill herself. But, by adopting a resolutely interpretive attitude, particularly concerning the patient's murderous impulses towards those whom she loved, he helped the patient emerge from this paranoid state. The rest of the treatment, its final phase, "ran a smooth course", and after another four months the patient terminated the treatment, saying she had now "found a way of living my own life" (p. 166).

Masud Khan presents this as an example of how the patient was helped by the analyst through a period of deep regression into making a good recovery from a very severe depression. However, even on its own terms, it is not clear why the so-called period of regression should be picked out as the critical or crucial part of the treatment. Indeed the whole analysis itself comes over as beset by enormous technical difficulties, as the patient seems to lurch from crisis to crisis, and oscillates between periods when she could be reached by the analyst and periods when she could not. For instance, the phase which comes shortly after the recovery from the regression, described as a resolutely paranoid phase with a constant background threat of suicide, seems to be no less disturbing and taxing for the analyst to find a way of responding to, no less challenging to the adequacy and adaptability of his technique, and no less critical a period to be managed if the analysis was not to founder at that point. Furthermore, other crucial phases of the analysis, particularly the ending, risk being glossed over as mere examples of 'classical analysis', as opposed to the more dramatic descriptions of the so-called phase of regression.

The assumption that there is a special phase of a treatment or type of work where the normal considerations of analytic technique no longer apply leaves no place to consider how the two phases or types of work link up with each other. For instance, Masud Khan does not seem to wonder what it means that this so-called period of regression ended with a suicide attempt, and was followed by a period of paranoia in which the patient regarded the whole analysis as having been a hoax – whether these might represent an unconscious commentary by the patient on how she experienced the analyst's conduct during the period of regression and his change-over to a more normal analytic technique in the subsequent phases of the analysis.

What happens if one does away with the whole idea of a therapeutic regression in this case? In my view, what can then emerge is a more coherent and plausible clinical account, one which links all the phases of the analysis together as instances of a powerful and insistent manic-depressive cycle (Lucas, 1998). In Masud Khan's account the manic parts of this cycle are already well described, for example, in the first part of the analysis when the patient re-assesses her therapy into her own version of the truth, or in the coldly superior paranoid phase. But now what Masud Khan describes as the period of regression would instead be seen as the emergence of the psychotically depressed part of the cycle. A similar reading of the so-called regressed state would be to cast it as a version of a 'thin-skinned' narcissistic state, as a counterpoint to the 'thick-skinned' manic and paranoid states, characterized by the patient seeking to manage a devastating puncture of self-regard brought about by the rejections by her husband (and, in the transference, by the analyst?) by adopting a self-pitying attitude of "continually abasing himself, looking for agreement and denying difference" (Bateman, 1998, p. 15).

Discussion and concluding remarks

In a detailed critique of (mainly North American) writings on regression, Inderbitzin and Levy argue that they rely on a concrete and outmoded model of development, which consists of “attempts to find states of mind in the past paralleling current, unexplained, adult states of mind, and then utilizing the past to explain the present by fixation or regression” (2000, p. 215). The problem, they say, with such a simplistic view is that it diverts attention from what might be going on in the patient’s mind. I think this is borne out in both of these examples. When recounting his patient’s “extreme reaction” to the “catastrophe” of the changed set-up of the consulting room, Winnicott has nothing to say of his understanding of her state of mind at this point, the assumption being that she is in some sense re-living a past experience of having been traumatically let down. For Masud Khan there is also little to explore once he has decided that his patient is in a severely regressed state of mind, which for him seems to mean a kind of experiential point zero. But if one were to recast such experiences not as examples of severe regression and therefore beyond further analytic description, but as experiences amenable to analytic understanding, for instance, as states of aggrieved and / or object depression, they then become open to exploration as to how they have arisen, how they may link to other states of mind exemplified by the patient (e.g. periods of manic flight or omnipotence), and also what they may indicate about the prevailing state of the transference (e.g. the patient’s rage or hopelessness about feeling misunderstood by the analyst). One might then wonder whether the analyst’s assumption of almost total responsibility for the patient in these examples is more to do with the projection by the patient of the capacity to think and act into the analyst, a projection all the more powerful when suicide is a prominent feature (Bateman, 1998; Gabbard, 2003), which can then put enormous pressure on the analyst to see a very ill or traumatized patient as requiring special treatment (Gabbard, 1986). This neglect of the operation of ordinary projection and transference is a consequence of the analyst construing the clinical space as an exclusively dyadic one:

For Freud there are three people, one of them excluded from the analytic room. If there are only two people involved then there has been a regression of the patient in the analytic setting, and the setting represents the mother with her technique, and the patient is an infant.

(Winnicott, 1954a, p. 286)

The problem is that this blots out the triangular or oedipal space within which analytic thinking and self-observation can take place (Britton, 1989, pp. 86–7).

These accounts appear one-sided in another sense, in that they rely on explicit appeals to the analyst’s authority and knowledge – he just knows, or ought to know that the patient is in a severely regressed state, and what the patient then ‘needs’ the analyst to do in order to manage such a state of affairs. This way of thinking is at odds with what Gabbard and Drew, in their contemporary review of the concept of therapeutic action, characterize as a key feature of contemporary psychoanalytic practice: “the negotiation process that takes place in each analytic dyad” (2003, p. 825). The assumption when it comes to these cases of so-called severe regression is that no such negotiation is possible – the analyst either accepts the regression, or finds ways of avoiding or short-circuiting it. Looking at these examples in terms of the negotiation process offers a different and, in my view, a

more informative perspective. In Winnicott's example, I would argue that what was really therapeutic was how he enabled the patient to negotiate her experience of having been let down by Winnicott rather than, as Winnicott has it, his ability to foster his patient's regression. In Masud Khan's example, it is the significant inability or refusal of the patient to allow a negotiation process which comes over as the most salient feature of the analysis, a perspective which is obscured by bringing in the idea of the patient needing a sustained period of regression in the analysis.

The conclusion one might then come to is that the concept of therapeutic regression is simply too ambiguous, too laden down with outmoded associations and ideas, too compromised to form the basis for a clinical strategy, and so no longer worth its place in psychoanalytic thinking. This is where I have come to in my own thinking. The fundamental problem with therapeutic regression as a concept is that it is essentially a reactive concept, dependent on a certain view of classical technique to which it serves as a challenge. Historically it has played a part, perhaps a significant part, in what in the 1950s and 1960s were called in America the "widening scope discussions" (Dreher, 2000, p. 124), that is, debates amongst psychoanalytic practitioners of how to respond to the more personality-disordered types of patients that were starting to come forward for treatment, and who did not respond well to the way psychoanalysis was practised at the time (Rey, 1994, p. 8). Balint, for example, writing in 1968 refers to his position, as an advocate of regression, as being on the fringe of a "classical massive centre" (1968, p. 155). However, this classical massive centre has now given way to what Gabbard and Drew describe as "a pluralism unknown in any prior area" (2003, p. 825). As a consequence the very notion of a standard or ordinary analytic technique has now been considerably widened.

Furthermore, what were once novel and radical ideas concerning therapeutic regression have now been incorporated into more modern concepts and clinical strategies. A good example is the distinction between interpretations aiming at conveying understanding, and those that aim to give the patient an experience of being understood. Writing of the patient who appears to hate any idea of the meaningful contact involved in being understood by the analyst, Steiner comments that the patient still "needs the analyst to register what is happening and to have his situation and his predicament recognized" (1993, p. 132, *italics added*), using language that seems to me to embody much of what is meant by therapeutic regression. For these reasons it is not surprising that many contemporary reviews of psychoanalytic technique make no mention of the therapeutic use of regression – the concept is not mentioned in Gabbard and Drew's paper, for instance.

Nevertheless a case can still be made for there being something of value in these clinical accounts. What they succeed in illustrating, in a particularly compelling way, are some of the consequences of taking to the limit one of the basic assumptions, or implicit meanings (Dreher, 2000, p. 169) that underpins and animates the whole idea of therapeutic regression. This is the idea that analysts should strive to model themselves on the image of a devoted and nurturing mother holding or containing her helpless and dependent infant. It is a model that clearly inspires Masud Khan's description of how he saw it as part of his role to take over some of the care-taking functions while his patient was in the full swing of her regression. A variant of this image is what Henri Rey (1994) called a 'brick mother', that is, a practitioner striving to attain the solidity and reliability of a substance, such as one

of the four elements (Balint, 1968, p. 69). This is how Winnicott sometimes seems to conceive of himself. In his close attention to the location of the objects in his consulting room it is as though Winnicott thought of the setting as an extension of his body, and so endowed it with a physical presence which would literally hold his patient. In another description of a session with a regressed patient, Winnicott describes how he knew he must remain absolutely still, “scarcely breathing”, as though he felt he had to approach the consistency of a solid object (1954a, p. 290).

While the extensive reliance in analytic thinking on the concepts of holding and containment testifies to the productiveness of this maternal metaphor, there is a danger when this metaphor becomes the exclusive one. Other metaphors – for example, the image of an oedipal mother, that is, a figure tied to a structure which opens out onto a horizon of other people, ideas and institutions, or a way of thinking based on the fundamental asymmetry between patient and analyst (Baranger et al., 1983, p. 1) – then become devalued or pushed out of the frame. Furthermore, perhaps as a consequence of an over-reliance on one model, there is a tendency towards concrete thinking (Inderbitzin and Levy, 2000, p. 271), of taking the metaphor literally: “in the extreme case the therapist would need to go to the patient and actively present good mothering” (Winnicott, 1954a, p. 282). The problem is not only one of the conflation here of the symbolic and the literal. It is also to do with a particular feature of the maternal metaphor itself as a sustaining image for a therapist, which is that it does not allow the analyst any subjectivity of their own. It is a construction made entirely from the infant’s supposed point of view. The term ‘mother’ here is not a person, and has no existence other than as a function for the infant (Baraitser, 2007).

However, it could also be argued that it is the very refusal of such an attitude to fit into more contemporary ways of thinking about analysis that gives it its value. It is clear that for many writers, even if the more worked-out version of regression as in the idea of therapeutic regression remains problematic, there is still life in the concept of regression itself, and that the loss of such a concept through any form of “concept-reflecting discourse”, that is, a discourse that examines concepts as to their adequacy and meaningfulness (Dreher, 2000, p. 165), would outweigh any possible benefits. In its evocative sense the idea of psychoanalysis being uniquely concerned with the primitive still strikes a chord, as in Bion’s aphorism: “Winnicott says patients need to regress: Melanie Klein says they must not regress; I say they are regressed” (quoted in Britton, 1998, p. 71) And when used in a clinically focused way to signal the value of non-intervention in some clinical situations, one can still find examples in the literature which use the idea of regression as a way of calling up the analyst’s creativity and imagination in responding to difficult clinical situations, whether it be a state of extreme withdrawal (White, 2006b, pp. 20–2), finding a way of speaking directly to the psychotic part of the patient (Bromberg, 1991, p. 417), or used as a way of drawing attention to the uniquely personal part of the countertransference (Coen, 2000). One can even find arguments for the clinical value of the idea of regression turning up in unexpected places (Britton, 1998, pp. 70–81).

It is true that, like Inderbitzin and Levy (2000, p. 220), I have come to a more radical position, finding not only the concept of therapeutic regression but the more generic term ‘regression’ itself too empty of meaning to be useful. Whenever I now encounter the word ‘regression’, or the term ‘regressed patient’, I find I have to do a quick bit of mental translation: which form of regression is meant, to what

and from what does the writer mean to welcome this development or not, and what is the writer trying to get at by introducing the term? Nevertheless, as Dreher reminds us, it is part of the very “liveliness” of psychoanalysis that none of its basic concepts command consensus amongst practitioners about what they actually mean (2000, p. 164). What matters is not only the conceptual clarity of a concept, but also how far clinicians can engage with it and use it to extend their thinking, and many psychoanalytic writers continue to invoke the idea of regression. And even if the concept of therapeutic regression, which transforms the more generic notion of regression into a more worked-out and substantial clinical concept, now seems outmoded and of dubious clinical value, an investigation of its usefulness can still provoke questions as to what is really therapeutic in our work.

Translations of summary

Gibt es in der Psychoanalyse noch einen Platz für das Konzept der “therapeutischen Regression”? Als Grundlage seiner Untersuchung der Bedeutung und Nützlichkeit des Konzepts der therapeutischen Regression dient dem Autor die eigene Ratlosigkeit ob der Frage, wo dieses Konzept in seinem klinischen Denken und in seiner Praxis einen Platz finden könnte. Er trifft eine Unterscheidung zwischen drei Bedeutungen, in denen der Begriff “Regression” im psychoanalytischen Diskurs benutzt wird: als Möglichkeit, eine primitive Ebene des Erlebens zu bezeichnen, als Erinnerung daran, dass dem Verzicht auf Interventionen in bestimmten klinischen Situationen ein hoher Wert zukommt, und als Beschreibung einer Phase in der analytischen Behandlung mancher Patienten, in der der Analytiker die normale analytische Technik beiseite lassen muss, um eine Regression des Patienten zu unterstützen. In ebendieser dritten Bedeutung als “therapeutische Regression” wird der Begriff im vorliegenden Beitrag untersucht, und zwar vor allem in Form einer ausführlichen Diskussion zweier klinischer Beispiele für so genannte therapeutische Regressionen, die von Winnicott bzw. von Masud Khan stammen. Der Autor vertritt die Ansicht, dass der klinische Prozess durch die Einführung des Konzepts der therapeutischen Regression in diesen Beispielen eher verdunkelt als geklärt wird. Er zieht den Schluss, dass das Konzept als klinisches Konzept nicht länger hilfreich ist. Er weist jedoch auch darauf hin, dass viele psychoanalytische Autoren weiterhin eine Verwendung für das eher generische Konzept der Regression haben und dass die Auseinandersetzung mit dem spezifischeren Konzept der therapeutischen Regression insofern wertvoll ist, als sie zu Fragen nach dem, was in der psychoanalytischen Behandlung tatsächlich therapeutisch wirkt, anregt.

¿Sigue habiendo lugar para el concepto de ‘regresio’ n terapéutica’ en el psicoanálisis? El autor aprovecha su propia imposibilidad de hallar un lugar para la idea de regresio n terapéutica en su pensamiento clínico o en su práctica como base para una investigación de su significado y utilidad. Distingue tres usos del término ‘regresio n’ en el discurso psicoanalítico: como la manera de evocar un nivel primitivo de experiencia; como un recordatorio en algunas situaciones clínicas del valor de la no-intervención por parte del analista; y como la descripción de una fase de tratamiento analítico con algunos pacientes donde el analista necesita poner de lado la técnica analítica normal a fin de fomentar una regresio n en el paciente. Esta tercera acepción, a la que el autor denomina ‘regresio n terapéutica’ es la que este artículo examina, sobre todo mediante una amplia discusión de dos ejemplos clínicos de pacientes que hacen la denominada regresio n terapéutica, uno brindado por Winnicott y el otro por Masud Khan. El autor argumenta que en estos ejemplos la introducción del concepto de regresio n terapéutica más bien oscurece en vez de clarificar el proceso clínico. El autor concluye que, como concepto sustancialmente clínico, la idea de regresio n terapéutica ha sobrevivido a su utilidad. Sin embargo señala que muchos autores psicoanalíticos continúan encontrando un uso para el concepto más genérico de regresio n, y que la propia aproximación a la idea más particular de regresio n terapéutica tiene el valor de provocar preguntas como ‘¿qué es lo que es realmente terapéutico en el tratamiento psicoanalítico’.

Existe-t-il encore une place pour le concept de « régression thérapeutique » en psychanalyse? L’auteur part de son propre échec trouver une place pour l’idée de régression thérapeutique dans sa pensée et sa pratique clinique pour en rechercher son sens et son utilité. Il distingue trois façons dont le terme « régression » est utilisé dans le discours psychanalytique : comme une façon d’évoquer un niveau primitif de vécu; comme un rappel, dans certaines situations cliniques, de la valeur de non-intervention de la part de l’analyste; et comme une description d’une phase du traitement analytique de certains patients où l’analyste est dans la nécessité de mettre de côté la technique analytique normale pour encourager la régression chez le patient. C’est ce troisième sens, que l’auteur nomme « régression thérapeutique », qui est étudié ici, au moyen d’une discussion approfondie autour de deux exemples cliniques de patients traversant ce qui a été appelé une régression thérapeutique, l’un issu de l’œuvre de Winnicott, l’autre de celle de Masud Khan. L’auteur soutient que dans ces exemples, l’introduction du concept de régression thérapeutique obscurcit plutôt qu’elle n’éclaire le processus clinique. Il conclut que, en tant que concept clinique

substantiel, l’id e de la r gression th rapeutique a surv cu son utilit . Cependant il note galement que de nom-
breux auteurs psychanalystes utilisent encore le concept g n rique de r gression, et que ce r el engagement pour l’id e
particuli re de r gression a le m rite de susciter des questions sur ce qui est r ellement th rapeutique dans le traite-
ment psychanalytique.

Il concetto di ‘regressione terapeutica’ ha ancora un posto in psicoanalisi? L’autore muove dalla sua
esperienza di non essere riuscito a dare il giusto spazio al concetto di regressione terapeutica nella sua teorizza-
zione e prassi clinica per esplorare il significato e la validit di tale concetto. Propone nel suo studio tre accezioni
del termine ‘regressione’ nel discorso psicoanalitico: pu essere un modo di evocare un livello primitivo dell’esper-
ienza; o un termine inteso a ricordare in alcune situazioni analitiche l’utilit di una tecnica di non-intervento da
parte dell’analista; oppure la descrizione di una fase del trattamento analitico di alcuni casi in cui l’analista deve
mettere da parte la normale tecnica analitica al fine di incoraggiare una regressione del paziente. 8 questa terza
accezione del termine, definita dall’autore ‘regressione terapeutica’, che questo lavoro intende esaminare, principal-
mente mediante un’estesa discussione di due esempi clinici di cosiddetta ‘regressione terapeutica’, uno descritto da
Winnicott e l’altro da Masud Khan. L’autore sostiene che in questi esempi l’introduzione della nozione di regres-
sione terapeutica, offuschi, piuttosto che chiarire, questo concetto clinico. L’autore conclude che, attualmente,
questo concetto non riscontri pi successo come strumento psicoanalitico. Egli nota tuttavia che molti autori di
psicoanalisi continuano ad usare il termine nella sua accezione pi generica, mentre la discussione sul sopracitato
concetto di regressione terapeutica ha una validit intrinseca in quanto solleva la questione di cosa sia realmente
terapeutico nel trattamento psicoanalitico.

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